

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

163-028718

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 749 Primary Registration District No. 002 Registrar's No. 4016 STATE FILE NUMBER

FILED AUG 6 1963

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in b. <u>1 month</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>34 West 57th. Terr.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANGELA</u> Middle <u>ELIZABETH</u> Last <u>TRIPODI</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-1902</u>
9. AGE (last birthday) <u>61</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>
11a. FATHER'S NAME <u>John Fitz Maurice</u>		11b. MOTHER'S MAIDEN NAME <u>Honor Laffey</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		13. SOCIAL SECURITY NO. <u>[redacted]</u>	
14. INFORMANT <u>Mrs. Patricia Loyd</u>		Address <u>34 West 57th. Terr.</u>	
15. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ABDOMINAL CARCINOMATOSIS WITH ASCITES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS.</u>	
DUE TO (b) <u>ADENOCARCINOMA OF CECUM</u>		5 MOS.	
DUE TO (c) <u>MILD UREMIA</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>[redacted]</u> a.m. <u>[redacted]</u> p.m. <u>[redacted]</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>JUN 1, 1963</u> to <u>JUL 15, 1963</u> and last saw her alive on <u>JUL 14, 1963</u>		Death occurred at <u>1:30 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>James W. Fowler, M.D.</u>		22b. ADDRESS <u>1103 Grand Ave.</u>	
22c. DATE SIGNED <u>7-16-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-16-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Mellody-McGilley-Eylar 20 W. Linwood</u>		25. DATE RECD. BY LOCAL REG. <u>7-16-63</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

JAMES W. FOWLER MEDICAL CERTIFICATION

Mr. James Fowler
Prof. Bldg.
Ba 1-0630

Mon: will call for
educational Rehabilitation
Argyle Bldg. before
1:00 PM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Herb F. Duckman

Licensed Embalmer No. 5120

P. O. Address KC 11, MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.